PHYSICIAN PAYMENT REVIEW COMMISSION

COMMENTS ON THE PRESIDENT'S BUDGET FOR FISCAL YEAR 1993

NO. 92-6

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PREFACE

This report was prepared to fulfill the Commission's obligation under Section 4118 of the Omnibus Budget Reconciliation Act of 1990 (OBRA90; Public Law 101-508) to "comment on recommendations affecting physician payment under the Medicare program that are included in the budget submitted by the President pursuant to Section 1105 of Title 31, United States Code."

Anne Schwartz was the Commission staff member principally responsible for the analysis in this report.

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COMMENTS ON THE PRESIDENT'S BUDGET FOR FISCAL YEAR 1993

In this report, the Commission first comments on recommendations included in the President's fiscal year 1993 budget request affecting physician payment under the Medicare program. These include payment for anesthesia services, funding for Medicare's carriers, and funding for the research programs of the Health Care Financing Administration (HCFA). Second, because the Congress has expanded the Commission's mandate to health care reform issues beyond Medicare physician payment, the report also considers programs falling within these other areas of the Commission's work. These include funding for the Agency for Health Care Policy and Research (AHCPR), community and migrant health centers funded under Sections 329 and 330 of the Public Health Service Act, the National Health Service Corps, and health professions training.

MEDICARE PROPOSALS

The Administration's budget proposal contains three provisions relevant to physician payment. The Commission comments here on payment for anesthesia services, funding for Medicare's carriers, and funding for the Health Care Financing Administration's Office of Research and Demonstrations.

Payment for Anesthesia Services

In last year's budget and again this year, the Administration has proposed setting a single fee for anesthesia services, regardless of whether an anesthesiologist personally performs the service or medically directs a certified registered nurse anesthetist (CRNA). In effect, the supervising anesthesiologist would receive the residual between the payment that would be made to a solo anesthesiologist providing the same service and the payment that is made to the medically directed CRNA. Savings of $100 million are estimated.

CRNAs have two statewide conversion factors, one for medically directed CRNAs and one for nonmedically directed CRNAs. The conversion factor for nonmedically directed CRNA services is capped at the anesthesiologist's level for the locality.[1]

[1] OBRA90 specified national dollar conversion factors for nonmedically directed CRNAs that were based on the expected conversion factor for anesthesiologists under the Medicare Fee Schedule. In fact, the 1992 fee schedule conversion factor for anesthesiologists is lower than anticipated, resulting in national conversion factors of $13.94 for anesthesiologists and $15.75 for nonmedically directed CRNAs. But because OBRA90 included a provision capping the CRNA conversion factor at the anesthesiologists' level, actual payments to nonmedically directed CRNAs will not exceed those of anesthesiologists.

When an anesthesiologist and a CRNA work together on a case, two payments are made -- one to the anesthesiologist and one to the CRNA. Thus, the total payment for a case provided by a team exceeds payment for the same service provided by a solo anesthesiologist or a nonmedically directed CRNA. Using the example of an inguinal hernia repair, total per case payment in 1991 for a case involving an anesthesiologist supervising a CRNA while also supervising a second case (1:2 ratio) is 21 percent more than payment to an anesthesiologist performing the service alone. Using the same service as an example, payment to the anesthesia care team is expected to be 36 percent more than payment to solo anesthesiologists by 1996.

In its 1991 *Annual Report to Congress* (PPRC 1991), the Commission recommended that the total fee for the services of an anesthesiologist and a CRNA working as a team should not exceed the payment made to a solo anesthesiologist for the same service. This is consistent with the Administration's proposal. The Commission's recommendation was also contingent, however, upon revision in the OBRA90 conversion factors for medically directed CRNAs. The Commission believes that the conversion factor specified in OBRA90 would provide little or no incentive to anesthesiologists to work with CRNAs in a care team. Hourly payments to anesthesiologists supervising two or three CRNAs (currently the most common ratios of care observed) would be less than if they provided the service alone.

The Commission also advises that a one-payment system be phased in. This would prevent anesthesiologists who practice in states where the conversion factor is currently below the national average from suffering large payment cuts until they are brought up to the national Medicare Fee Schedule conversion factor. One way that a transition could be achieved would be to create a floor below which anesthesiologists' conversion factors could not fall. This could be set at the national average and financed with some of the savings from the new policy of one payment.

Funding for Program Management by Contractors

The Administration has requested $1.644 billion to fund Medicare's carriers and fiscal intermediaries. This amount is $187 million more than that appropriated in FY 1992, but no contingency fund has been established. By contrast, for FY 1992, $1.457 billion was appropriated plus a $257 million contingency fund. To date, $69 million of these contingency funds have been released, bringing the current total operating costs for FY 1992 to $1.526 billion.

In general, this funding level appears appropriate to ensure efficient program operations in the coming fiscal year. The Commission recommends, however, that an additional $50 million contingency fund be created. Such a contingency fund is needed because the availability of sufficient funding depends heavily on the success of proposed administrative changes discussed below in achieving substantial savings. Should these proposals fail to

produce the expected savings, carriers could face a substantial shortfall in program management funds. It is the Commission's understanding that shortfalls would be made up by cutting payment safeguard activities, the operations that prevent Medicare overpayments and abusive billing practices. Reliance on this source to ensure carriers have sufficient funding is a short-sighted approach and ultimately does not serve taxpayers well. The availability of contingency funds would preclude the need to cover shortfalls from payment safeguard funding.

In addition, the Commission questions the wisdom of two of the proposed changes to promote more efficient administrative operations and achieve budget savings: consolidating contractor functions and capping cost reimbursement. It also questions whether the assumption regarding increased use of electronic media claims (EMC) is realistic. The Commission is pleased, however, that the budget includes sufficient funding for beneficiary toll-free hotlines.

Functional Consolidation. The budget requests authority to transfer any carrier and intermediary function from inefficient contractors, defined as those at the 20th percentile of efficiency or below, to more efficient contractors for an estimated savings of $3 million. Because functional consolidation has the potential to complicate claims processing, the Commission questions the trade-off between saving a relatively small amount of contractor funds and disrupting program operations.

Cap Cost Reimbursement. The budget proposes saving $13 million by capping cost reimbursement to contractors at the 60th percentile of all contractors' unit costs incurred two years earlier. This proposal is flawed in two respects. First, it assumes that all costs above the 60th percentile are attributable to inefficiency when in fact they may reflect differences in the cost of doing business, such as variations in local labor markets and investments in capital. Second, contractors are already being paid substantially below levels recommended by the Health Care Financing Administration's own industrial engineering studies. Further cuts may force contractors to leave the program, with tremendous disruption for physicians and beneficiaries as recently occurred when Missouri Blue Cross and Blue Shield withdrew from administering Medicare Part A.

Electronic Media Incentives. Finally, the budget assumes savings of $65 million by creating incentives for electronic submission of claims. The proposal sets the payment floor at 14 days for electronic media claims and increases that for paper claims to 27 days. Because many carriers are already paying electronic claims at 14 days, these savings will be achieved only if the number of electronic claims increases from the current 48 percent to 55 percent next year and to 75 percent in 1994. Carrier representatives predict, however, that such increases are unrealistic. While the percentage of claims received electronically has grown dramatically, the rate of future increases is expected to slow.

Funding for the Health Care Financing Administration's Office of Research and Demonstrations

The President's budget would reduce funding for HCFA research, demonstrations, and evaluations by more than half. The requested level is $36 million, down from $78 million in FY 1992. The decrease is due to the proposed discontinuation of funding for three grant projects: rural health care transition grants, the Essential Access Community Hospital/Rural Primary Care Hospital (EACH/RPCH) program, and support for state efforts to counsel Medicare beneficiaries on supplemental insurance options. In its FY 1992 budget, the Administration also proposed discontinuation of these projects, which were subsequently funded by the Congress. Because the Commission has not previously considered the merit of these programs in any depth, it cannot comment on whether these proposed cuts are appropriate.

For the general research budget, the Administration has proposed funding of $36 million, an increase from FY 1992 of only $389,000. In the Commission's view, these activities are dramatically underfunded relative to total federal expenditures for Medicare and Medicaid. With proposed spending in FY 1993 of $144 billion on the Medicare program and $84 billion for the federal share of Medicaid, the proposed general research budget represents less than .02 percent of federal expenditures on these programs.

The Commission recommends that the current budget for general research be doubled. Although the agency plans to conduct studies on a wide range of issues including physician and hospital payment, quality of care, coordinated care, access, and long-term care, a more substantial investment in research and development would likely lead to better program management, reduced use of unnecessary services, and better care for Medicare and Medicaid patients.

The Commission is also concerned about the adequacy of funding for HCFA's research projects to update and refine the new physician payment system. Among the issues the Commission is particularly concerned about is future work on development of a resource-based practice expense component for the Medicare Fee Schedule. In its recent report (PPRC 1992), the Commission recommended that HCFA develop and evaluate the impact of changing to a resource-based methodology. It also recommended that HCFA collect additional data to support calculation of resource-based practice expense relative values. Sufficient resources should be devoted to this critical research task.

OTHER PROPOSALS

Under OBRA90, the Congress substantially expanded the Commission's mandate to include health system reform issues beyond physician payment under Medicare. Because the Commission is now focusing on a broader set of interrelated policies affecting the

financing, quality, and delivery of health services, it comments here on the Administration's proposals for the Agency for Health Care Policy and Research, community and migrant health centers, the National Health Service Corps, and health professions training. Funding levels and priorities for these programs are relevant to the Commission's work on quality of care, medical malpractice reform, access to primary care and other services in inner-city and rural areas, and the supply and specialty distribution of physicians.

Funding for the Agency for Health Care Policy and Research

The Administration has proposed a $5 million increase for the Agency for Health Care Policy and Research to bring total funding for the Agency to $125 million, a 4 percent increase over fiscal year 1992. The Commission is concerned that this amount is still substantially below the Agency's fiscal year 1992 authorization level of $230 million and that it is insufficient to fund the range of activities the Congress had envisioned the Agency would undertake.

Expectations were created that research and policy analysis funded by AHCPR would make major contributions to our knowledge about medical effectiveness, efforts to enhance quality, and mechanisms to improve access to health care for vulnerable population groups. Yet despite the breadth of this mission, the Agency's budget is only 0.015 percent of total national health expenditures.

A more substantial investment in the Agency's extramural research activities has the potential to improve our ability to understand and manage health care services, reduce use of unnecessary services, better meet the needs of patients, and develop new, more efficient delivery systems. Because of insufficient funding, however, the Agency has been forced to put some of its plans on hold. These include studies on medical information systems, evaluations of state-initiated quality assurance and risk management systems, and community-based clinical effectiveness trials to support the work of the Patient Outcome Research Teams (PORTs). Studies related to medical liability have also languished due to funding constraints. The Commission recently recommended that the Agency fund studies on defensive medicine, the effects of malpractice reforms on patients, and the etiology, classification, and prevention of medical injury. It also recommended that the Agency promote development of systems and databases for early detection of medical injury and design of effective preventive measures. These and other projects, however, cannot be launched on the existing budget.

The Commission recommends that the Agency's budget be increased to $150 million in fiscal year 1993 as a first step towards the goal of increasing funding to the authorized level. This increase could be accomplished through a variety of mechanisms. For example, the fiscal year 1992 general appropriation level could be maintained and the increase gained by adding from the Medicare trust funds $37.8 million as requested by the Administration. The Administration's budget request also proposes a substantial sum from

the Public Health Service's 1 percent evaluation funds. The Commission's primary concern, however, is that regardless of the source of funds, sufficient funding must be made available for the Agency to pursue its mission effectively.

In addition, the entire amount of the requested increase for the Agency is designated for its Medical Treatment Effectiveness Program (MEDTEP) with no increase for general health services research and technology assessment. Studies in these areas are critical to development of effective strategies to address many problems affecting the nation's health system, including cost containment, quality improvement, and access to care. Moreover, in some cases, general health services research provides the tools and methods necessary for the work of the PORTs and guideline development. Yet the number of health service research grants has slowly but steadily declined, from 112 grants in fiscal year 1991 to the proposed 90 grants in fiscal year 1993. The National Advisory Council for Health Care Policy, Research, and Evaluation, appointed by the Secretary of Health and Human Services to monitor the Agency's performance, has also recently emphasized the need for substantial additional funding for general health services research and research training efforts.

With regard to MEDTEP, the Commission has also recommended funding priorities for the Agency's work on practice guidelines, suggesting that it place greater emphasis on development of guidelines that improve the value of health care by addressing its cost as well as its quality. In addition, it recommended that the Agency establish a practice guidelines clearinghouse and that it fund research to identify efficient and effective methods of producing guidelines.

Funding for Community and Migrant Health Centers

The Administration has requested $684 million for community and migrant health centers (C/MHCs) funded under Sections 329 and 330 of the Public Health Service Act. This represents an increase of $90 million (about 15 percent) over FY 1992. This amount of funding is projected to support 110 to 130 additional C/MHC sites serving 400,000 persons.

An increase in funding for community health centers is consistent with the Commission's recommendations in its 1992 report for a substantial increase in funding for community health centers, given their potential as a means of improving access for Medicaid beneficiaries (PPRC 1992).

Funding for the National Health Service Corps

The Administration has requested $120 million for the National Health Service Corps, an increase of $20 million over FY 1992 but still below its peak strength of $154 million in 1980. The Commission also recommended in its 1992 report that the National Health

Service Corps be expanded to meet the needs of underserved populations (PPRC 1992). It commends the Administration for promoting a revitalized Corps.

Most of the increase ($11 million) is proposed for four new initiatives: two early recruitment and retention programs targeted at minority teenagers and college students, training for scholars, and professional enhancement programs for Corps physicians in C/MHCs. While the Commission recognizes these efforts may play a role in revitalizing the Corps, it is concerned that the Administration plans to fund only five more scholarships than in the current fiscal year (increasing from 460 to 465) and anticipates entering into the same number of state and federal loan repayment agreements (185 and 250 agreements, respectively). The Commission questions the decision not to expand significantly the pipeline of new scholars, particularly as the number of applications for scholarships and loan repayments far exceeds the number of those funded.

Funding for Health Professions Training

The Administration's budget proposes no funding for numerous health professions training programs under Titles VII and VIII of the Public Health Service Act. These include support for training and faculty development in family medicine, general internal medicine, and general pediatrics (funded at $59.9 million in FY 1992), training for nonphysician practitioners skilled in primary care ($24.5 million in FY 1992), service-linked education networks such as the Area Health Education Centers and geriatrics training centers ($127.2 million in FY 1992), and training in disciplines such as nursing, preventive medicine, and public health ($26.6 million in FY 1992). Overall, the President's budget requests only $96 million for health professions training programs funded at $288 million in FY 1992, and at $254 million in FY 1991. The Commission is deeply concerned about termination of these programs that form the core of federal efforts to encourage practice in primary care fields and in underserved areas.

The Administration justifies these deep cuts with two arguments. First, the proposal questions the need for federally supported training when the nation has a surplus of physicians. Second, the proposal cites the availability of funding through Medicare direct education payments, the Health Education Assistance Loan (HEAL) program, and other Department of Education sources.

These arguments do not hold up on closer scrutiny, however. First, as noted in the Commission's 1992 *Annual Report to Congress*, growth in physician supply over the past three decades has not resulted in a spillover of a sufficient number of providers into underserved areas or primary care specialties (PPRC 1992). While some small gains have been made in rural areas, many inner cities remain unserved and student interest in primary care fields has been steadily declining. As a result, even under conditions of increasing physician supply, the nation is training too few primary care physicians relative to the number of medical subspecialists and specialists in some surgical fields. Second,

other sources of financing do not encourage students to enter primary care disciplines. If anything, financing graduate medical education primarily through Medicare inpatient revenues has impeded the development of training programs in these fields. The Commission strongly opposes elimination of these vital and consistently underfunded programs.

REFERENCES

Physician Payment Review Commission, *Annual Report to Congress 1991* (Washington, DC: PPRC, 1991).

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